FILM

How Bollywood came to a Welsh hospital

Ophthalmologist's film explores medical migration

Perhaps it is the close-up view of an intracapsular cataract extraction just minutes into the film's opening scenes that gives the first clue that this is no ordinary romance; or perhaps it is the warning that "this film is representative of contemporary life … [but] any resemblance to any person, living or dead, is coincidental." But for many in the UK medical world it will be the unexpected appearance on the big screen of strangely familiar faces and places that gives the game away.

For *Bhavishya: The Future* is more "Bollywood meets medical documentary meets health education promo" than a standard feature film. What it lacks in cinematic polish and performer professionalism it certainly makes up for in curiosity value.

The man behind it is Nikhil Kaushik, a consultant ophthalmologist at Wrexham Maelor Hospital in North Wales. He says: "I long debated that first shot [of the eye surgery]. More normally in films you'll see a surgeon throwing a bottle of blood around, but that's not what it's like. This gives more a sense of the reality of theatre."

Kaushik, a graduate of Maulana Azad Medical College in Delhi, came to Britain in 1977 and has been in Wrexham since 1987. His interest in the arts found an early outlet in television and radio in India and has continued in this country mainly through poetry, prose, and a greater than usual enjoyment found in the preparation of teaching material.

He can thank the government's waiting list initiative for his debut as a script writer and film director, for it enabled him to find sufficient cash to plough into the *Bhavishya* project. It was either that or buy a yacht, he explains. And, he says, he is not into yachts.

"I'd been watching how the medical profession is portrayed in films, and usually they're villains, killing people, or fighting with managers," he adds, explaining *Bhavishya*'s genesis. "The reality is a different one in which you are balancing many things. Today you might be operating on a seriously ill patient, and tomorrow you might have an interview 200 km down the road. It's an unsettled life that people lead. That's what I wanted to say; and gradually a story brewed up and so I put it down on paper."

The resulting film explores issues concerning medical migration—east to west and vice versa. More specifically it tells of the developing love between two young medics: one a young doctor from Delhi who finds Britain's relatively better staffed and better managed hospitals, as well as the opportunities abroad for professional advancement, a lure too great to resist; the other a British Asian who, though shocked by the workload and work conditions faced by his counterparts in India, is also torn by the rights and wrongs of taking work abroad. In more than a nod towards Bollywood style, *Bhavishya* features lavish song and dance sequences.

It has been a labour of love for Kaushik too. Many of his weekends, evenings, and days off over the past year have been taken up with shooting—in Wrexham and its surrounds, including scenes inside Wrexham Maelor itself ("The management has been very supportive"), as well as in Delhi, Haridwar, and, thanks to a spot of filming during down time while he attended a conference, even Dubai.

Kaushik initially planned to employ actors for his film, he explains, but "I realised I could get a more realistic film if I cast from the profession itself." Hence the romantic leads, Akansha Tyagi and Vikrant Gautam, are both students coming to the end of their third year at Manchester Medical School. He also put word out among colleagues at Wrexham Maelor that he was looking for interested amateurs and was pleasingly surprised by the interest. Among those subsequently cast were consultant dermatologist Rob Lister, consultant gynaecologist Bid Kumar, and consultant anaesthetist Simon Underhill. All "rose to the occasion," he says.

Even the medical director of North East Wales NHS Trust, Peter Rutherford, has got in on the action, albeit playing himself, chairing a meeting.

The scenes in India too feature real doctors (Harish Bhalla and Renu Nigam), and that opening eye surgery scene was filmed in a Delhi operating theatre. (Other surgery images come from Kaushik's own teaching collection.)

A real coup was the casting of the veteran TV and film star Saeed Jaffrey. He appears as himself as the star guest in a party scene—a scene in which Kaushik, who plays a holy man, can also be spotted.

Kaushik says he hopes to find a general audience for his "off-beat" film. Showings in Wrexham, Cardiff, and Manchester are being planned, and he is currently looking for a distributor. The music is already on course to be released this summer, and a website is under construction (www.bhavishya-thefuture.com).

However, Kaushik, who has spent £100 000 on the film, says: "Making the money back is not an issue. I just wanted to do it.

"I'm passionate about surgery too," he adds.

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Medical realism: Manchester medical students Vikrant Gautam and Akansha Tyagi play the romantic leads

Items reviewed are rated on a 4 star scale (4=excellent)

NETLINES

● Looking to expand your vocabulary, want a new quotation every day, or need a dictionary reference source? www.thefreedictionary.com may well be the answer to your quest. This collection of excellent resources includes a medical dictionary, a legal dictionary, and help with acronyms. If you want to expand your horizons further, there is an article of the day, as well as hangman and a word quiz. The dictionary set up alone is worth a place in your favourites file, but there is much more than that here. This is a fun, educational site.

● Online "match making" sites make particularly clever use of the potential of internet technology. www.gpmatch.com is one such example. It brings British general practices and locums together, allowing them to see if they can work with each other. It's free, provides a potentially useful service, and can help locums find work and practices find suitable temporary doctors. The stats section sets out how many locums are available in a geographical area and the maximum hourly and average rates.

● Fed up with a patient bringing a newspaper or magazine cutting to you, containing inaccurate medical information? Among the sites that seek to redress the balance is Health News Review (www.healthnewsreview.org). This scans the popular press for health related stories, selects some of them for review, appraises them using a scoring system, and writes a commentary. There is also a link back to the original story. The site is largely modelled upon the pioneering effort begun by an Australian team that launched the Media Doctor (www.mediadoctor.org.au) website in 2004 (see *BMJ* 2004;329:178).

● We increasingly hear about investigations for eGFR or estimated glomerular filtration rate, which is based on a creatinine level and other variables such as age and sex. If this is all news to you and you want to learn more, check out www.renal.org/eGFR/about.html. This user friendly British based site provides background information and points about interpreting the results; it also has a simple to use online calculator.

● For an energetic blog visit http://emeritus.blogspot.com. This is written by a doctor based in Manila in the Philippines and is mainly aimed at the patient who wants to know more. However, health professionals will find much of the material interesting, relevant, and the author links to a large number of resources. The blog is regularly maintained, opinionated, well designed, and fun to read.

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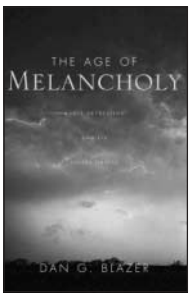
We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address.

The Age of Melancholy: Major Depression and its Social Origins

Dan G Blazer



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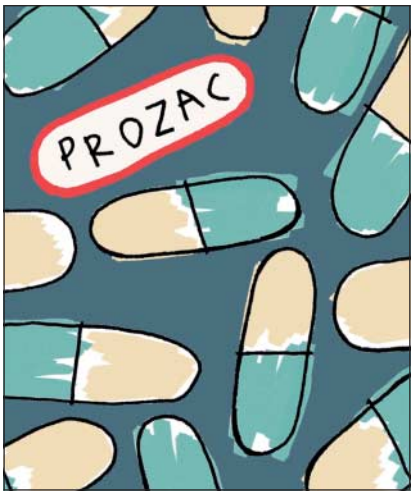
ISBN 0415951887
www.routledge.com

Rating: ★★☆☆

Some people find postmodernism infuriating; some find it puzzling; others yawn. But love it or loathe it, the postmodern critique of psychiatry is here to stay. For some people, though, postmodernism is like a fashion accessory: something to don to create an impression. This, I felt, is the approach taken in *The Age of Melancholy*.

Blazer's central thesis is that the waning of social psychiatry and the rise of biological psychiatry are related. He develops this idea to argue the case for a new form of social psychiatry. This is a potentially interesting argument—after all, psychiatry is prone to different types of dualism, body-mind and mind-society being the most obvious. The reason Blazer's thesis is important is that it has the potential to engage with the body-culture dualism and thus open up new insights into the biological body, something he tries to do at the end of his book but fails, as he lacks a self-critical perspective.

Blazer begins by describing changes in the classification of depression, pointing out that the demise of the category "reactive depression" and the rise in popularity of "major depressive disorder" are mirrored by changes in approaches to treatment, in particular the decline of psychotherapy and psychoanalysis and the rising popularity of treatment with antidepressants. There is nothing new here. Others, notably Alice Bullard ("From vastation to Prozac nation," *Transcultural Psychiatry* 2002;39:267-94) and Bradley Lewis (*Moving beyond Prozac, DSM, and the new psychiatry*, University of Michigan Press, 2006) have described the ascendancy of a drug culture at the end of the 20th century. Both these writers draw heavily on analyses that describe this phenomenon in terms of cultural changes in the meaning and significance of biology and the body.



SPL

What does the rise of drugs like fluoxetine (Prozac) say about our understanding of depression?

Early in Blazer's book he speaks of the causal links between social factors and depression. But where a postmodern approach would lead an author to question the use of adjectives such as "causal" he sees no problem with it. He then asks if it is possible for psychiatrists to observe a phenomenon without understanding it, but he does so without questioning the assumption that knowledge in psychiatry is neutral and objective. This indicates that he has failed to come to grips with the problem of epistemology or how we know about the world. In chapter 3 he surveys the changes in meaning of the word depression since the time of Hippocrates. This is fine, but in the previous chapter he examines the rise of major depression and the biological theories associated with this while failing to subject the meaning of these concepts to the same level of cultural scrutiny. It is acceptable, it seems, to subject a historically distant cultural epoch to a critical cultural gaze, but why exclude our own period from such an analysis? Presumably Blazer believes that contemporary psychiatric knowledge is beyond any form of cultural analysis.

In the final chapters he takes us on a whirlwind tour of postmodernism. There are hints at the postmodern condition. A little postmodern theory is thrown in for seasoning. This is what I mean by postmodernism functioning as a fashion accessory. It is difficult to understand what function this section of the book serves. He certainly hasn't used these ideas as a way of examining the assumptions his knowledge makes. His recipe for the reinvigoration of social psychiatry is more of the same: more empirical research and social epidemiology. His argument that the emotions enable us to link body and culture has merit, but he has nothing to offer beyond more empirical research as a means to exploring this. If we are to grapple with the problems set out by Blazer we have to step beyond the boundaries of psychiatry and turn to other disciplines, especially philosophy, anthropology, and cultural theory. We have to be prepared to turn the spotlight on ourselves. Blazer fails to meet this challenge. The problems that he raises are important ones for medicine and psychiatry. His analysis is simply not up to it.

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PERSONAL VIEW

Senior doctors must stay part of the picture

As I walked out of a provincial hospital in Germany the other day, I noticed in the foyer a board with the names and photographs of all the institution's medical staff proudly displayed. Later, when I got home, a check on the website showed these same names just one click in from the home page, complete with qualifications and notes of their specialist interests.

Clearly these staff were important to the hospital, an asset to be advertised. That is perhaps hardly surprising. Patients come to a hospital in the expectation of the best treatment, and treatment is carried out by a specialist team. At the head of each team is a senior clinician and it is upon the quality of that consultant that the outcomes for the patient depend. He or she leads the team, sets the standards, conducts the diagnoses, and supervises the treatment.

Having worked and travelled extensively elsewhere in Europe and America, I have realised that the phenomenon of hospitals expressing pride in the quality of their senior clinical staff is widespread. Except, it seems, in Britain. Try, as a patient, looking for any outward sign that UK hospitals place any special value on their consultant staff, and the search will be a frustrating one. Look up the websites of any of our university, teaching, or district general hospitals, and attempt to find any prominence given to the clinicians who supervise the individual services, or even their names.

Over the past 20 years in the NHS there has been a process of progressive emasculation of medical staff in the hospital service. The process accelerated after Bristol, Alder Hey, Ledward, and the general spin-off from Shipman. Successive governments saw their opportunity, like spotting a frightened rabbit caught in one's headlights. And to be honest, the medical profession, potentially the most powerful of all professions, has done little to resist.

But why this process? To any government, doctors are dangerous. They are dangerous for two reasons. Firstly, the huge power of the doctor-patient relationship—a patient is treated by "my doctor," not "the" doctor. A patient's wellbeing or even life is personally in that doctor's hands. Politicians cannot bear that affinity. It gets in the way of all manner of policy decisions. Secondly, modern medicine becomes expensive each year vastly beyond the rate of inflation because of the pace of modern medical research. Just think—30 years ago there were no coronary artery bypass grafts, no heart transplants, no computed tomography or magnetic resonance imaging, no microsurgical replantations, no expensive oncological drugs, to name but a fraction of the reasons for increased spending. And who determines those tests and treatments? The consultant and his or her team. Therefore, in a state controlled health system, the government must, above all else, get control of these spendthrifts whose decision making also affects virtually every activity in every hospital—ward activity, bed occupancy, operating theatre activity, bodies going to the mortuary, pathology laboratory activity, admissions, discharges, and much more.

Part of the process of weakening consultants and their medical support has involved the anonymisation of the role. Hence the progressive diminution of medical profile, the rise of nurse consultants, the removal of doctors' dining rooms, 360° assessment, common car parking, and many other privileges. Then there has been the erosion of individual responsibility and replacement by guidelines, written policies, catch-all consent forms, and the need for constant revalidation and assessments, the validity for all of which has yet to be given one iota of scientific verification—despite pressures on doctors to prove the merits of their own treatment outcomes.

> Only the managers and the jobsworths are left to lead the institution

Recently there has been yet another powerful move to weaken the individuality of the consultant specialist. The practice of generic referrals from general practitioners, at first denied but now expected by primary care trusts. Thus a referral to a hospital department rather than to a named specialist (my own department's postbag now has well over 50% of Dear Doctor, Dear Colleague, or Dear Team referrals) takes away the right of any given consultant to see the patient and also allows the hospital "ownership" of the referral even to the extent of shipping it out to the private sector when expedient.

So what, one might say. Who cares? And the more egalitarian might also say we have no right to be different from anyone else in the institution. Fair enough, but the true value of the real professional—an asset never valued in the NHS, and impossible to quantify on any hospital finance officer's balance sheet—is the willingness to take responsibility, to shoulder risks, to work on until the job is done, to update one's knowledge constantly. And when that value becomes diminished, then leadership goes too. And only the managers and the jobsworths are left to lead the institution. And that is what is happening now in the NHS. And that is why, in wiser countries with better organised health systems, the pictures of the senior doctors are still displayed at the front of the hospital or on its website.

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SOUNDINGS

Suicidal thinking

Suicide was medicalised long before birth and death were. The church considered suicide a grave sin and refused to bury people who had ended their lives "by their own hand," as did Judas, who—according to the Gospel of St John—hanged himself. It may be argued that Judas had good reason to do so; nevertheless, the construct that suicide is the result of insanity secured Christian burial for many centuries.

Whether religious or not, most people think that destroying oneself is against human nature and therefore irrational.

Psychiatrists regard suicide as a matter under their jurisdiction, because a proportion of people who take their own lives are "mentally ill," whatever that may mean. The guidelines casualty departments use to treat people who have attempted suicide imply that such people are considered insane.

One wonders what psychiatrists think of religious suicide? Religious suicide usually poses as self sacrifice in the process of killing others and has been considered a heroic deed eligible for sanctification. The motivation of a suicide bomber, a Kamikaze pilot, many a crusader, knight, and martyr, was and is the belief in some sort of reward in an afterlife. Religious fanaticism may be considered as social pathology but is it, at the individual level, a psychiatric disorder?

Are all people who contemplate or commit suicide depressed, mentally disturbed, or religious fanatics? There may be rational reasons to want to arrange one's own death. Socrates drank hemlock in full possession of his mental powers. Cleopatra chose the venom of the asp to avoid humiliation. The writer Arthur Koestler took poison because he was old, ill, and had lost his creativity. The Hungarian novelist Sándor Márai shot himself, having taken handgun handling lessons from the police, because he was lonely, old, and barren.

With increasing life expectancy and incurable chronic disease, rational suicide is bound to become more common. A new species is suicide by writ: "just in case" instructions with regard to the discontinuation of life support.

Suicide is not necessarily a matter of insanity, irrationality, or despair, and it is not primarily of medical concern. Would Goering, if he had had a psychiatrist, have preferred the gallows to cyanide?

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